

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

04912

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and OR- give nearest town) TOWN <u>Havre de Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Barlinton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Jean</u> (Middle) <u>Rose</u> (Last) <u>Ashley</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 2 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 19, 1920</u>
9. AGE last birthday <u>30</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Richardson, Joseph</u>		14. MOTHER'S MAIDEN NAME <u>Bella Gilley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Lacey Ashley</u>		18. MEDICAL CERTIFICATION <u>Kimberly Perma</u>	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Gastrointestinal Hemorrhage - cause

## Antecedent cause(s)

(b) unknown -(c) Thrombocytopenia, chronic

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 25, 1951, to May 2, 1951, that I last saw the deceased alive on May 2, 1951, and that death occurred at 3:10 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>May 3, 1951</u>	<u>West Jefferson M. C.</u>	<u>North Carolina</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>May 3, 1951</u>	<u>G. L. Lewis M.D.</u>	<u>H. S. Bailey</u>	<u>Barlinton Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1921

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-04913

1. PLACE OF DEATH- COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Md.</i> COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harrods Grace</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harrods Grace</i>	
TOWN <i>Harrods Grace</i>		TOWN <i>Harrods Grace</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>111 Bloomsbury St</i>		STREET ADDRESS (If rural, give location) <i>111 Bloomsbury St</i>	
3. NAME OF DECEASED (Type or Print) <i>Lewis</i> (First) <i>Robert</i> (Middle) <i>Baldwin</i> (Last)		4. DATE OF DEATH <i>May 17 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct. 29 1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lafore</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired 2 yrs</i>	9. AGE last birthday <i>71</i> yrs.
13. FATHER'S NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>218-03-4563</i>	
(If year, give war or dates of service) <i>—</i>		17. INFORMANT AND ADDRESS <i>Mrs. Mary E. Jones</i>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <i>Pulmonary Edema</i>			<i>1 day</i>
Antecedent cause(s) (b) <i>Pulmonary Tuberculosis</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Active - Bihateral Lunges - Arthritis</i>			<i>10 yrs.</i>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <i>SUICIDE</i>	PLACE (Home, farm, factory, street, office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>m.</i>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>May 17, 1957</i> to <i>May 17, 1957</i> , that I last saw the deceased alive on <i>May 17, 1957</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Wm. Wheeler M.P.</i>		ADDRESS <i>Harrods Grace Md</i>	DATE SIGNED <i>5/19/57</i>
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	DATE <i>May 19 1957</i>	NAME OF CEMETERY OR CREMATORY <i>Angel Dell</i>	LOCATION (City, town, or county) (State) <i>Harrods Grace Md</i>
DATE REC'D BY LOCAL REG. <i>May 19-1957</i>	REGISTRAR'S SIGNATURE <i>A. L. Lewis M.D.</i>	24. FUNERAL DIRECTOR <i>H. Madison Mitchell</i> ADDRESS <i>Harrods Grace Md 970 VV</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAY 22 1951  
MILWAUKEE

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04914

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH: COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Deposit</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>86 N. Main Street</u> ✓	
3. NAME OF DECEASED (Type or Print) <u>George Elmer Blackburn</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8-28-78</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Station Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Blackburn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ferguson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Hazel McKay, 96 N. Main St, Port Deposit, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Pulmonary Embolism

## Antecedent cause(s)

(b) Carcinoma of Rectum(c) 46d  
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

30 months6 monthsII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>5-7-51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Rectum</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		CITY OR TOWN (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4/16, 1951, to 5/22, 1951, that I last saw the deceased alive on 5/22, 1951, and that death occurred at 9:32 Am., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>5-25-1951</u>		NAME OF CEMETERY OR CREMATORY <u>Lafayette Ave.</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 24 - 1951</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		24. FUNERAL DIRECTOR <u>W. A. Patterson &amp; Son</u>		ADDRESS <u>621 6th St, Pikesville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A-15

RECEIVED  
MAY 28 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04915

## CERTIFICATE OF DEATH

Reg. Dist. No. 186-

1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVER DE GRACE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Aberdeen R.T.D.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>		STREET ADDRESS (If rural, give location) <u>Bush Chapel Road.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>CATHERINE</u>	(Middle) <u>Mary</u>	(Last) <u>BOND</u>
4. DATE OF DEATH	(Month) <u>MAY</u>	(Day) <u>25</u>	(Year) <u>1951</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>5-24-51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>HAVER DE GRACE, MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLARENCE BOND</u>		14. MOTHER'S MAIDEN NAME <u>MARION HOKE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Clarence Bond, Aberdeen R.T.D., Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) ASPHYXIA NEONATORUM

## Antecedent cause(s)

(b) FETAL DYSTOCIA

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from MAY 24, 1951, to MAY 25, 1951, that I last saw the deceased alive on MAY 25, 1951, and that death occurred at 1:15 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>MAY 25 1951</u>	<u>St. Mary Cemetery</u>	<u>Aberdeen Harford Co. Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>MAY 25 - 1951</u>	<u>G. L. Lewis M.D.</u>	<u>Henry Harrington &amp; Sons</u>	<u>Aberdeen Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 29 1951  
BUREAU OF S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

04918

Reg. Dist. No. 185-

1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harve De Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>B. D. 1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>William</u> (Middle) <u>EDWARD</u> (Last) <u>Brooks</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>5-16-51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs. <u>16</u> Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Harford Memorial Hosp.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Edward Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Rosalie Catherine H &amp; L</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Bel Air, Md. (father)</u>	
17. INFORMANT AND ADDRESS			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) congenital syphilis

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-17, 1951, to 5-17, 1951, that I last saw the deceasedalive on 5-15-51, 1951, and that death occurred at 130 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED 5-17-51

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May-19-1951 A. L. Lewis M. D.H. S. BaileyDartington, Md.205161191406

MARGIN RESERVED FOR BINDING

VS. A15

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RECEIVED  
MAY 22 1961  
BUREAU

VS A15

RECEIVED  
MAY 8 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

04917

Reg. Dist. No. 182

1. PLACE OF DEATH - COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kelmina</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Eugene</u>	(Middle) <u>S</u>	(Last) <u>Ball</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>19</u>	(Year) <u>1957</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 5, 1870</u>
9. AGE last birthday <u>80</u> yrs.		10. AGE last birthday (If under 1 year) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hartford Co - Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Dr. John F Ball</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Hollingsworth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT AND ADDRESS <u>Elmer H Ball Pylesville, MD</u>			

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) CEREBRAL THROMBOSIS

#### INTERVAL BETWEEN ONSET AND DEATH

5/15/51

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Gen Arteriosclerosis

(c) Malnutrition

12 mos

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 4, 1950 to May 19, 1957, that I last saw the deceased

alive on May 18, 1951, and that death occurred at 12:10 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Wesley P. Hudson, M.D. Forest Hill, Md 5/19/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATOR

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 21/51 Thomas Runn Mather, Jr. Near Bel Air Md 5/20/51 Wesley P. Hudson Joseph J. Tuley, Baltimore

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 24 1954  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH: COUNTY <u>Harford</u> <u>Mem. Hosp.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> TOWN <u>Harford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> TOWN <u>Harford</u> STREET ADDRESS (If rural, give location) <u>651 Franklin Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Max</u> (Middle) (Last) <u>Bullock</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>31</u> (Year) <u>1951</u>	5. SEX <u>Male</u> 6. COLOR OR RACE <u>white</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> 8. DATE OF BIRTH <u>1-1-1893</u> 9. AGE last birthday <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Store Owner</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u> 12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Simon Bullock</u>	14. MOTHER'S MAIDEN NAME <u>Anna ?</u>		
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Mrs. Fannie Bullock-651 Franklin Street Harford De Grace, Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work Not While At work

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-18, 1951, to 5-31, 1951, that I last saw the deceased

alive on 5-31, 1951, and that death occurred at 4:00 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

04920

Reg. Dist. No. 180

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Unknown</u> COUNTY <u>Unknown</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Unknown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2151-1 US Army Hospital Aberdeen Proving Ground</u>		STREET ADDRESS (If rural give location) <u>Unknown</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LEON</u>	(Middle) <u>N.</u>	(Last) <u>CRIST</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>26</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Unknown</u>
9. AGE last birthday <u>28</u> yrs.		10. AGE last birthday <u>Unk</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY No. <u>-----</u>	
17. INFORMANT <u>Personal effects of deceased</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Fracture skull</u>	<u>none</u>
(b) <u>Immediate cause</u>	
(c) <u>Antecedent cause(s)</u>	
<u>8165</u> Diseases or conditions, if any, giving rise to the above cause	
<u>170c</u> stating the underlying cause last	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.
---

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>US Route 7</u>	(CITY OR TOWN) <u>Edgewood</u> (COUNTY) <u>Harford</u> (STATE) <u>md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 26, 1951 8 P.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Auto accident: auto auto type</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) Dezard C Palmer MD Deputy Medical Examiner Harford Co. Balt in md. DATE SIGNED 5/27/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>May 29, 51</u>	NAME OF CEMETERY OR CREMATORY <u>Paul</u>	LOCATION (City, town, or county) (State) <u>7 P. Druman Ark</u>
DATE REC'D BY LOCAL REG. <u>May 29, 1951</u>	REGISTRAR'S SIGNATURE <u>Marie M. Mondsall</u>	24. FUNERAL DIRECTOR <u>Howard K. McConner &amp; Son</u>	ADDRESS <u>Aberdeen md 595916</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

\* App returned from Ref. Unit. E/pw. 6/13/51.

BUREAU V. S.

JUN 4 1951

RECEIVED

Sgt. R A 37417141

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04921

## CERTIFICATE OF DEATH

Reg. Dist. No. 186-

1. PLACE OF DEATH: COUNTY <u>Harford</u> <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> <u>Harford</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Havre de Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Havre de Grace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>401 Market</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary Elizabeth Deibert</u>		4. DATE OF DEATH <u>5/18/51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>11/2/1873</u>
9. AGE last birthday <u>77</u> yrs.		10. If under 1 year Months <u>8</u> Days <u>18</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Seeds</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Florence E. Deibert, Havre DE Grace, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Kidney Disease

INTERVAL BETWEEN ONSET AND DEATH

1 day

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Myocardial Failure1 week

(c)

Massive Cerebral Hemorrhage1 week

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hemiplegia Left1 week

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Not While  
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 10, 1951, to May 18, 1951, that I last saw the deceasedalive on May 18, 1951, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.  
May 20-1951REGISTRAR'S SIGNATURE  
G. L. Lewis M.D.

## 24. FUNERAL DIRECTOR

ADDRESS

Pennington & Son, Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04922

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH: COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> TOWN <u>Harford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>-</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> TOWN <u>Harford</u> STREET ADDRESS (If rural, give location) <u>667 Boulton</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Marshall Rubin Diehl</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5/21/51</u> <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/23/1900</u>
9. AGE last birthday <u>51</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Edgewood Arsenal</u>	
11. BIRTH PLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Diehl</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Marshall R. Diehl, Harford, Md.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Gravid varicella hemorrhage

Antecedent cause(s)

(b) Multiple Pancreatic Cysts

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 day

1 year

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar 27, 1951, to May 21, 1951, that I last saw the deceased

alive on May 4, 1951, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/24/51</u>	NAME OF CEMETERY OR CREMATORY <u>Bakers</u>	LOCATION (City, town, or county) <u>Abundant, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>May 23-1951</u>	REGISTRAR'S SIGNATURE <u>A. L. Lewis M. D.</u>	24. FUNERAL DIRECTOR <u>Pennington</u>		ADDRESS <u>Harford, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 25 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04923

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH: COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>834 OTSEGA ST</u>	
3. NAME OF DECEASED (First) <u>Edward</u> (Middle) <u>DANIEL</u> (Last) <u>EVANS</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S.</u>	8. DATE OF BIRTH <u>6-29-50</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>0</u> yrs. <u>10mo</u> <u>18</u> Days
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward EVANS</u>		14. MOTHER'S MAIDEN NAME <u>JEAN RAPALI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Father: Edward EVANS 834 Otsega ST</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

Acute fulminating Hepatitis

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Multiple Gastric ulcers - hemorrhagicAcute mesenteric adenitis

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## INTERVAL BETWEEN ONSET AND DEATH

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

## 20. AUTOPSY?

Yes ☒ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-17, 1951, to 5-18, 1951, that I last saw the deceasedalive on 5-18, 1951, and that death occurred at 10<sup>30</sup>A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

2066290251405

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED  
MAY 22 1951  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

04924

1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAURE DE GRACE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAURE DE GRACE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>		STREET ADDRESS (If rural, give location) <u>400 MARKET ST.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>VESTA</u> (Middle) <u>MAE</u> (Last) <u>GIBSON</u>	4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 7, 1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE last birthday <u>42</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Baldwin</u>		14. MOTHER'S MAIDEN NAME <u>MARY ALICE SANTMYER</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

4 days

## Antecedent cause(s)

(b)

Hypertensive Heart Disease

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Diabetes Mellitus

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY 18, 1951, to MAY 22, 1951, that I last saw the deceasedalive on MAY 22, 1951, and that death occurred at 12:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

MAY 23-1951W. R. Lewis M.D.Funeral HomeHarford County

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 25 1951  
BUREAU Y. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

04925

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HARFORD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HARFORD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP</u>		STREET ADDRESS (If rural, give location) <u>401 Union Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Emma</u> (Middle) <u>MAE</u> (Last) <u>GORELL</u>	4. DATE OF DEATH	(Month) <u>5</u> (Day) <u>24</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>3-10-98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret. Government Worker</u>	9. AGE last birthday <u>53</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nich A. Gorell</u>		14. MOTHER'S MAIDEN NAME <u>Ida Opperman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Brother Wilson A. Gorell Delta, PA.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Coronary OcclusionHypertensive Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-14-51, to 5-24-51, 1951, that I last saw the deceasedalive on 5-24-51, 1951, and that death occurred at 8:45 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 28 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

04926

Reg. Dist. No. 185-

1. PLACE OF DEATH COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> LENGTH OF STAY (in this place) <u>12 yrs.</u> TOWN <u>Havre de Grace</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> TOWN <u>Havre de Grace</u> STREET ADDRESS (If rural, give location) <u>214 Strawberry Alley</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Willie</u> (Middle) <u>Green</u> (Last) <u>Green</u>		4. DATE OF DEATH (Month) <u>5/1/51</u> (Day) <u>19</u> (Year) <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/1/1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ideal Diner</u>	9. AGE last birthday <u>50</u> yrs. If under 1 year <u>2</u> Months <u>2</u> Days If under 24 hrs. <u>10</u> Hours <u>10</u> Min.
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marcellus Green</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Gardner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>215 - 03 - 6637</u>	
17. INFORMANT AND ADDRESS <u>Georgia A. Green, Havre de Grace, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute Myocardial Infarction</u>			<u>8 wks</u>
Antecedent cause(s) (b) <u>Coronary Sclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension &amp; generalized arteriosclerosis</u>			<u>10 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9/13, 1950, to 5/1, 1951, that I last saw the deceased alive on 4/30, 1951, and that death occurred at 6:35 a.m., from the causes and on the date stated above.

SIGNATURE George T. Standbury M.D. ADDRESS Havre de Grace, Md. DATE SIGNED 5/3/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>5/5/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	LOCATION (City, town, or county) (State) <u>Near Aberdeen, Md.</u>
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DATE REC'D BY LOCAL REG <u>May 3 - 1951</u>	REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	24. FUNERAL DIRECTOR <u>Wilmington &amp; Son</u>	ADDRESS <u>Havre de Grace, Md.</u>
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MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

754679

RECEIVED

MAY 7 1951

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

04927

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fallston</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fallston</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>ALFRED</u> (Middle) <u>H.</u> (Last) <u>HALL</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>m.</u>	6. COLOR OR RACE <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct. 30, 1861</u>
9. AGE last birthday <u>89</u> yrs. <u>6</u> months <u>16</u> days		10. BIRTHPLACE (State or foreign country) <u>near Rutledge, Harford Co. Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Isaac Hall</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Brown</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Ben E. Hall, Hyde, Md.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) CEREBRAL THROMBOSIS

INTERVAL BETWEEN ONSET AND DEATH

5-6-51

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized Arteriosclerosis

(c) Prostatism With Urinary Retention

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF	While at			
INJURY	Work <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from Aug. 20, 1949, to May 16, 1951, that I last saw the deceased alive on May 16, 1951, and that death occurred at 10:00 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 19, 1951</u>	<u>West Liberty</u>	<u>Upper Cross Roads, Harford Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>5/18/51</u>	REGISTRAR'S SIGNATURE <u>Willa Louwood</u>	24. FUNERAL DIRECTOR <u>Martin H. Kurtz</u>	ADDRESS <u>Jarrettsville, Md.</u>	

820105

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 31 1954  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

04928

1. PLACE OF DEATH: COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>NORTH Ohio ST.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>JACK</u> (Middle) <u>-</u> (Last) <u>HENDERSON</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 8, 1884</u>
9. AGE last birthday <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Keeper</u>	
11. BIRTHPLACE (State or foreign country) <u>Millwood Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John HENDERSON</u>		14. MOTHER'S MAIDEN NAME <u>CORNELIA STRANGE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Ada Henderson (wife) North Ohio ST.</u>			

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>1 day</u>
Antecedent cause(s) (b) <u>142X Anemia</u>		<u>5 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>131a Hypertensive Cardio-vascular renal disease</u>		<u>6 months</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>none</u>	(CITY OR TOWN) <u>Harve de Grace</u> (COUNTY) <u>Harford</u> (STATE) <u>Maryland</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>fall</u>

22. I hereby certify that I attended the deceased from May 20, 1951 to May 26, 1951, that I last saw the deceased alive on May 26, 1951 and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE Steven L. Williams M.D. ADDRESS Harve de Grace Md. DATE SIGNED 5/26/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 30, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Schantz Ch. Yard</u>	LOCATION (City, town, or county) (State) <u>Fairfax Co. Va</u>
DATE REC'D BY LOCAL REG. <u>May 28-51</u>	REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	24. FUNERAL DIRECTOR <u>R. Madson Mitchell</u>	ADDRESS <u>Harve de Grace Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290636

RECEIVED  
MAY 31 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04929

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

*Item 14, filed H&E 7 3/22/67 JCP*

1. PLACE OF DEATH- COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MASSACHUSETTS</b> COUNTY <b>MIDDLESEX</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>EDGEWOOD, Md.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Everett, Mass.</b>	
TOWN <b>EDGEWOOD, Md.</b> 3/12		TOWN <b>Everett, Mass.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U S Army Dispensary Army Chemical Center, Md.</b>		STREET ADDRESS (If rural give location) <b>-</b>	
3. NAME OF DECEASED (First) <b>JAMES</b>	(Middle) <b>None</b>	(Last) <b>JOHNSTONE JR</b>	4. DATE OF DEATH (Month) <b>May</b> (Day) <b>16</b> (Year) <b>1951</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>16 July 1929</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S Army</b>	9. AGE last birthday <b>21</b> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Everett, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES JOHNSTONE SR</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH JOHNSTONE ANN PROWER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY No. <b>ASN: RA1220577</b>	
(If year, give war or dates of service) <b>Present</b>		17. INFORMANT <b>-</b>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <b>Cardiac Failure</b>			<b>0830 - 0915</b>
Antecedent cause(s) <b>1754.3</b>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <b>Etiology unknown</b>			
(c) <b>Autopsy results: (1) Hypertrophy of the heart muscle of the left ventricle. (2) Patent foramen ovale, third degree. (3) Petechial hemorrhage in the left anterior heart muscle to the left of the coronary artery. (5/25/51 akc)</b>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <b>the left of the coronary artery. (5/25/51 akc)</b>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <b>SUICIDE</b>	PLACE (Home, farm, factory, street, office bldg., etc.) <b>INJURY Army Cml Ctr Md</b>	(CITY OR TOWN) <b>Edgewood</b>	(COUNTY) <b>Harford</b> (STATE) <b>Maryland</b>
TIME (Month) (Day) (Year) (Hour) <b>May 16 1951</b>	INJURY OCCURRED <b>While at Work</b> <input checked="" type="checkbox"/> <b>Not While At work</b> <input type="checkbox"/>	HOW DID INJURY OCCUR? <b>During organized Company Training</b>	

22. I hereby certify that I attended the deceased from **16 May**..., 19**51**, to **16 May**..., 19**51** that I last saw the deceased alive on **16 May**..., 19**51**, and that death occurred at **0915** Am., from the causes and on the date stated above.

SIGNATURE (Degree or title) **Leon A P Stein** ADDRESS **Major, MC, Post Surgeon, Army Chemical Center, Md** DATE SIGNED **16 May 1951**

23. BURIAL, CREMATION REMOVAL (Specify) **Removal** DATE **May 17, 1951** NAME OF CEMETERY OR CREMATORY **HE Neuderum Co** LOCATION (City, town, or county) **Everett Mass.** (State)

DATE REC'D BY LOCAL REG. **May 17, 1951** REGISTRAR'S SIGNATURE **Mane m monedala** 24. FUNERAL DIRECTOR **Howard S. Mc Brown & Son** ADDRESS **Abingdon Rd 342916**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 22 1961  
BUREAU A. S.  
D

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

04930

Reg. Dist. No. 185

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAURE DE GRACE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Abingdon</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>		STREET ADDRESS (If rural, give location) <u>Long Bae Harbord</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>PETER</u>	(Middle) <u>C.</u>	(Last) <u>LANDRY</u>
4. DATE OF DEATH	(Month) <u>MAY</u>	(Day) <u>30</u>	(Year) <u>1951</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Sept. 16, 1887</u>
9. AGE last birthday <u>63</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>NOVA SCOTIA</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>JEFFERY</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>Shock J. Landry Abingdon Md</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>	
Antecedent cause(s) (b) <u>hypertension</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-29, 1951, to 5-30, 1951, that I last saw the deceased alive on 5-30, 1951, and that death occurred at 4:55 P. m., from the causes and on the date stated above.

SIGNATURE E. J. Simon (Degree or title) ADDRESS Harford Md DATE SIGNED 5-30-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>June 3, 1951</u>	<u>Cotuitary</u>	<u>Abingdon Harford Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	M. FUNERAL DIRECTOR	ADDRESS
<u>June 5-1951</u>	<u>A. L. Lewis m. D.</u>	<u>Harford Md</u>	<u>Abingdon Md 29047</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 8 1951

BURNING V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

04931

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Perryman</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Abedeen</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2151-1 US ARMY HOSPITAL ABERDEEN PRGR, MD.</u>		STREET ADDRESS (If rural, give location) <u>102-G Rodman Rd - Chesapeake Gardens</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u> (Middle) <u>L.</u> (Last) <u>Lockett</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>31</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 28, 1918</u>
9. AGE last birthday <u>33</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u>	
11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John Willis Lockett</u>		14. MOTHER'S MAIDEN NAME <u>May Lindsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Current</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Wife - 102-G Rodman Rd - Chesapeake Gardens</u>			

18. MEDICAL CERTIFICATION Aberdeen, Md.

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

## Immediate cause

(a) Fracture, skull, compound, with partial evisceration of brain3 days

## Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.19a. DATE OF OPERATION 28 May 1951 19b. MAJOR FINDINGS OF OPERATION Compound, depressed, partial evisceration of brain

## 20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE Undetermined</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) <u>Perryman</u>	(COUNTY) <u>Harford, Maryland</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 28, 1951 7:55</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Patient was struck by train.</u>	

22. I hereby certify that I attended the deceased from 28 May, 1951, to 31 May, 1951, that I last saw the deceased alive on 31 May, 1951, and that death occurred at 10:10 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>June 1, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>San Antonio National</u>	LOCATION (City, town, or county) <u>San Antonio, Texas</u>
DATE REC'D BY LOCAL REG. <u>June 1 - 1951</u>	REGISTRAR'S SIGNATURE <u>Howard R. McCombs</u>	24. FUNERAL DIRECTOR <u>Howard R. McCombs &amp; Son</u>	ADDRESS <u>Aberdeen Md 21001</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
JUN 11 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

04932

Reg. Dist. No. 151

1. PLACE OF DEATH- COUNTY Harford MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Harford	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Aberdeen		CITY (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2151-1 US Army Hospital Aberdeen Proving Ground		STREET ADDRESS (If rural, give location) 303-A Aqusta St - Chesapeake Gardens	
3. NAME OF DECEASED (First) Michael (Middle) INFANT MALE (Last) Paul McDANIEL		4. DATE OF DEATH (Month) May (Day) 6 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, <del>WIDOWED</del> , <del>SEPARATED</del> (Specify) Single	8. DATE OF BIRTH 4 May 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min. 2
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Paul D. McDaniel		14. MOTHER'S MAIDEN NAME Evelyn Pannell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No	
17. INFORMANT AND ADDRESS Hospital Records			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Congenital heart disease - cyanotic type

2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4 May....., 1951, to 6 May....., 1951, that I last saw the deceased alive on 6 May....., 1951, and that death occurred at 3:15 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

F M Nenendorf M D

M. D. 2151-1 US Army Hospital, APG, Md. 7 May 1951

23. BURIAL, CREMATION OR MOVIAL (Specify) Burial	DATE THEREOF 6 May 1951	NAME OF CEMETERY OR CREMATORY Post Cemetery	LOCATION (City, town, or county) Aberdeen Maryland	(State)
DATE REC'D BY LOCAL REG. 6 May 1951	REGISTRAR'S SIGNATURE Willie H. Riley	24. FUNERAL DIRECTOR Henry Harrison & Sons		

205041272406

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAY 14 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04933

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air R.D.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
TOWN <u>6 days</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Courtesant Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>JESSIE</u> (First) <u>M.</u> (Middle) <u>McMILLAN</u> (Last)		4. DATE OF DEATH <u>May 10</u> (Month) (Day) (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 2, 1900</u>
9. AGE last birthday <u>51</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Elizabeth N.J.</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Corley</u>		14. MOTHER'S MAIDEN NAME <u>Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Geo V. McMillan Joppa Md</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CEREBRAL HEMORRHAGE

Antecedent cause(s)

(b) Essential Hypertension(c) 331X 83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

?

?

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 6, 1951, to May 10, 1951, that I last saw the deceased alive on May 6, 1951, and that death occurred at 6:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>May 14, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) <u>Baltimore</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>5/15/51</u>	REGISTRAR'S SIGNATURE <u>Willa Howard</u>	24. FUNERAL DIRECTOR <u>Howard K. McCombs &amp; Son</u>		ADDRESS <u>Abingdon Md</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 17 1951  
BUREAU A. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

04934

1. PLACE OF DEATH- COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Md.</b> COUNTY <b>Harford.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Pylesville, Rural.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Pylesville, Rural.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <b>Walter</b> (Middle) <b>Watt</b> (Last) <b>Morris.</b>		(Month) <b>May</b> (Day) <b>27</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed.</b>	8. DATE OF BIRTH <b>Sept. 7, 1876.</b>
9. AGE last birthday <b>74</b> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Owner.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford, County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Walter S. Morris</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Slade.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None.</b>	
17. INFORMANT AND ADDRESS <b>Mrs. James Hunter, Glyndon, Md.</b>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <b>Coronary occlusion</b>	<b>Sudden.</b>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <b>Coronary artery disease</b>	<b>6 mo.</b>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>none</b>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <b>June</b> , 1949, to <b>May 27</b> , 1951, that I last saw the deceased alive on <b>May 17</b> , 1951, and that death occurred at <b>4 P. m.</b> , from the causes and on the date stated above.			
SIGNATURE <b>Charles P. Jeff MD.</b>		ADDRESS <b>Street, Md</b>	
DATE THEREOF <b>5-31-51</b>		LOCATION (City, town, or county) (State) <b>Fawn Grove, Pa.</b>	
DATE REC'D BY LOCAL REG. <b>5/29/51</b>		24. FUNERAL DIRECTOR <b>Priscilla Brown</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100105

RECEIVED  
JUN 6 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

04935

1. PLACE OF DEATH- COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Magnolia</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>50 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Magnolia</u> TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Blanche</u> (Middle) <u>Leone</u> (Last) <u>Skilman</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>31</u> (Year) <u>1951</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 10, 1869</u>	9. AGE last birthday <u>81</u> yrs.	10. Under 1 year Months <u>12</u> Days <u>10</u> Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Abingdon Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>Benjamin Jeffers</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Fitzinger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>(11 yes, give war or dates of service)</u>	17. INFORMANT AND ADDRESS <u>Mrs. Robt. Fleethy, Magnolia Md.</u>		

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Arteriosclerotic CV disease

## Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.Diabetes Mellitus

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1/1, 1946, to 5/31, 1951, that I last saw the deceasedalive on 5/25, 1951, and that death occurred at 1:45P m., from the causes and on the date stated above.SIGNATURE (Degree or title) Gerald C Palmer M.D. ADDRESS Bel Air, Md. DATE SIGNED 5/31/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 3, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>60 Kesbury</u>	LOCATION (City, town, or county) <u>Abingdon Harford Md.</u>
DATE REC'D BY LOCAL REG. <u>June 3, 1951</u>	REGISTRAR'S SIGNATURE <u>James M. Monksdale</u>	24. FUNERAL DIRECTOR <u>Howard K. McCombs &amp; Son</u> ADDRESS <u>Abingdon Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

260X

BUREAU V. S.

JUN 7 1951

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH: COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Hanford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Old Lin Road</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesden Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hanford Convalescent Home</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) <u>GEORGE</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>May 4</u> 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9/27/1862</u>
9. AGE last birthday <u>88</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Mechanical Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. FATHER'S NAME <u>Kathleen Sley</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. MOTHER'S MAIDEN NAME <u>Mary Courtney</u>		14. INFORMANT AND ADDRESS <u>Mrs Mary C. Martin</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. MEDICAL CERTIFICATION		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CEREBRAL THROMBOSIS422, Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) Chr. Cardio-Vascular Disease

93d

(c) Gen. ArteriosclerosisII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Aug, 1950, to May 4, 1951, that I last saw the deceased alive on May 3, 1951, and that death occurred at 4:50 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 6 1951</u>	<u>Springfield</u>	<u>Berwyn</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/5/51</u>	<u>Willa Fourwood</u>	<u>Henry Tanning Sons</u>	<u>Chesden</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

290646 md

RECEIVED  
MAY 8 1951  
BUREAU V. S.

04937

Reg. Dist. No. 183-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Harford</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Rising Sun</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp.</u>		STREET ADDRESS <u>Rd. # 2</u>	
3. NAME OF DECEASED (Type or Print) <u>Robert</u>		4. DATE OF DEATH <u>May 19 1951</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>February 4, 1915</u>	
9. AGE last birthday <u>6 yrs.</u>		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Roscoe Rakes</u>		14. MOTHER'S MAIDEN NAME <u>Dollie Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Hoospital Records</u>	
17. INFORMANT <u>Hoospital Records</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Fracture skull</u>		<u>8 hours</u>	
(b) <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) <u>Fracture both bones R leg</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>May 18, 1951</u>		19b. MAJOR FINDINGS OF OPERATION <u>Auto accident, auto pedestrian type</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Auto 1</u>	
TIME (Month) (Day) (Year) (Hour) <u>May 18, 1951 6P m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Auto accident, auto pedestrian type</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Genel C Palmer M.D. Deputy Medical Examiner Harford Co. Bd Air, Md</u>		DATE SIGNED <u>5/19/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 23 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Friends Burial Ground</u>		LOCATION (City, town, or county) <u>Rising Sun Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>May 19-1951 G. L. Lewis M.D.</u>		24. FUNERAL DIRECTOR <u>J. E. Tyson Rising Sun Md.</u>	

RECEIVED  
MAY 22 1951  
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

04938

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Harpford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harpford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Harpford</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harpford Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>2313 E Federal Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Anthony</u> (Middle) <u>V.</u> (Last) <u>Rasmus</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 30, 1918</u>
9. AGE last birthday <u>32</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		11b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Joseph Rasmus</u>		14. MOTHER'S MAIDEN NAME <u>Julia Bonn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1940-1946</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Brother - Peter Rasmus</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Fracture Cervical Vertebra

INTERVAL BETWEEN ONSET AND DEATH none

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		CITY OR TOWN <u>Harpford</u> (COUNTY) <u>Harford</u> (STATE) <u>MD</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7/1/51</u> <u>8</u> P.m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Auto accident, Auto-pedestrian type</u>	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 15, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Balto National Cemetery, Frederick Rd Balto Md.</u>	
DATE REC'D BY LOCAL REG. <u>5/14/51</u>		REGISTRAR'S SIGNATURE <u>R.W. Palmer</u>		24. FUNERAL DIRECTOR <u>John J. Duda Inc 2829 Hudson St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

04939

1. PLACE OF DEATH- COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Havre de Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Havre de Grace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>505 At. Clair St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Hattie</u> <u>E.</u> <u>Richardson</u>		4. DATE OF DEATH <u>5/16/51</u> 19 <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Harford County</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Alfred Richardson, Havre de Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Apoplexy (Thrombosis)</u>		<u>Arteriosclerosis assoc. &amp; Hypertension</u>	<u>3-4 mos.</u>
Antecedent cause(s) (b) <u>Arteriosclerosis assoc. &amp; Hypertension</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic Gangrene</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12/27, 1950, to 5/16, 1951, that I last saw the deceased

alive on 5/15, 1951, and that death occurred at 12:35 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED  
George T. Hensbury, M.D. Havre de Grace, Md. 5/18/51

23. BURIAL, CREMATION, REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)  
Burial 5/18/51 St. James Havre de Grace, Md.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS  
May 18-1951 G. L. Lewis W. D. Pennington & Son Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED  
MAY 21 1951  
M. BRATT

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04940

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Darlington R. D.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Darlington Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>David</u> (Middle) <u>Langley</u> (Last) <u>Woods</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>28</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>unk.</u>	8. DATE OF BIRTH <u>About 24 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Unknown</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-01-0500</u>	
		17. INFORMANT AND ADDRESS <u>K. K. Wilkins Harford, Md</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Acute Pulmonary edema

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis of V Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

12 yrsII. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Aug, 1939, to May, 1957, that I last saw the deceased alive on May 27, 1957, and that death occurred at 6 a m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>May 29 1957</u>	<u>St. John's</u>	<u>Harford, Md</u>	<u>Md</u>
DATE REC'D BY LOCAL	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>July 6 1957</u>	<u>C. K. Kirk</u>	<u>H. S. Bailey, Darlington</u>		

970 VVV Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-415

RECEIVED  
JUL 11 1951  
BUREAU A. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

04941

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>Harford Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Delaware</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air, Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Md</u>	
TOWN <u>Bel Air, Md</u>		TOWN <u>Bel Air Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Theresa</u> (Middle) <u>McComish</u> (Last) <u>Worthington</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>31</u> (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Dec 7, 1854</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Bel Air Md</u>
13. FATHER'S NAME <u>James McComish</u>		14. MOTHER'S MAIDEN NAME <u>Mary J Holland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>John D Worthington Jr Bel Air Md</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cardio-respiratory failure</u>			<u>1 week</u>
Antecedent cause(s) (b) <u>Advanced Scurvy (Arteriosclerosis)</u>			<u>10 years.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>97</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June, 1947, to May, 1951, that I last saw the deceased alive on 18 May, 1951, and that death occurred at 5:15 P. m., from the causes and on the date stated above.

SIGNATURE <u>H. P. Reddick</u> (Degree or title) <u>M.D.</u>	ADDRESS <u>Bel Air Md</u>	DATE SIGNED <u>1 June 51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>June 2/51</u>	NAME OF CEMETERY OR CREMATORY <u>Seabury</u>
LOCATION (City, town, or county) <u>Bel Air Md</u>	(State) <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>6/1/51</u>	REGISTRAR'S SIGNATURE <u>Winella Saworth</u>	24. FUNERAL DIRECTOR <u>Joe Foster Bel Air Md</u>
		ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
JUN 6 1951  
BUREAU V. S.